

Norditropin® (human growth hormone)

Certificate of Medical Necessity

THERAPY INITIATION

PLEASE FILL IN ALL INFORMATION REQUESTED

*****PLEASE SUBMIT A GROWTH CHART WITH EACH CERTIFICATE*****

Patient Name: _____ GHI ID #: _____ DOB: _____

Initial Evaluation

Height: _____ cm Weight: _____ kg Age: _____
Percentile: _____ % Percentile: _____ % Bone Age: _____

Diagnosis

- | | | |
|--|---|--|
| <input type="checkbox"/> GH Deficiency (GHD) | <input type="checkbox"/> Adult w/ Pediatric Onset GHD | <input type="checkbox"/> Idiopathic Short Stature |
| <input type="checkbox"/> Turner's Syndrome | <input type="checkbox"/> Noonan's Syndrome | <input type="checkbox"/> Small for Gestational Age |
| <input type="checkbox"/> Chronic Renal Insufficiency | <input type="checkbox"/> Prader-Willi Syndrome | <input type="checkbox"/> Other _____ |

Prescription Information

- | | | |
|---|---|--|
| <input type="checkbox"/> Nordiflex 5mg/1.5ml pen | <input type="checkbox"/> Norditropin 5mg/1.5ml Cart. | <input type="checkbox"/> Norditropin 4mg- 1ml vial |
| <input type="checkbox"/> Nordiflex 10mg/1.5ml pen | <input type="checkbox"/> Norditropin 15mg/1.5ml Cart. | <input type="checkbox"/> Norditropin 8mg- 1ml vial |
| <input type="checkbox"/> Nordiflex 15mg/1.5ml pen | | <input type="checkbox"/> Other _____ |

Daily Dose _____ **mg/day** **Dose Frequency** _____ **sc inj/week**

Date Therapy Initiated: (if applicable) _____

DISCONTINUATION OF HGH will occur *in children* when one of the following criteria is met:

1. The patient fails to grow more than 2.5 cm/year.
2. When the patient epiphyseal closure occurs.
3. When the bone age is 16 years (in females) or 18 years (in males)

Physician Name: _____ Specialty: _____ License #: _____

Telephone#: _____ FAX#: _____

Please complete form and fax to:

Fax to: 1-877-300-9695

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